

COMMONWEALTH OF VIRGINIA

Virginia Department of Health Professions

Prescription Monitoring Program Perimeter Center

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REQUEST TO REGISTER AS AN AUTHORIZED AGENT TO RECEIVE INFORMATION FROM THE PRESCRIPTION MONITORING PROGRAM

Please provide the information	requested belo		Use full name not	initials
Name:		Position:		
Agency Name (Please Circle):				
DEA/DHP/HPMP/MEO/MFCU/DMAS/F	BI	Agent ID:		
Street Address		City		
State Virginia		Zip Code		rea Code and Telephone Number
Fax Number:	Email A	mail Address:		te of Birth:
I hereby attest that I am eligible to red Program. Sign Here and below:	ceive reports under	§54.1-2523 (B) or (C)	of the Code of Virginia	a from the Prescription Monitoring
Signature:		Date	9 :	
	(То Ве	AFFIDAVI e Completed Before a		
(Printed Name) registration with the Prescription				n referred to in this application for l is factual and complete.
				Signature of Applicant
Subscribed and sworn to me				of Virginia at large, on this on,
				Signature of Notary Public

I hereby attest that to receive reports from the Prescrip	is known to me and is an employe tion Monitoring Program pursuant to ६	e of entitled 54.1-2523 (B) or (C) of the Code of Virginia.			
Title:	Printed Name:				
Signature:	: Date:				
Subscribed and sworn to me, a n	otary public in and for the Commo	nwealth of Virginia at large, on this			
day of,, My commission expires on,					
		Signature of Notary Public			
Registration as an agent authorized to receive reports shall expire on June 30 of each even-numbered year or at any time as the agent leaves or alters his current employment or otherwise becomes ineligible to receive information from the program.					
For Department Use Only					
Date Received:	Director or Designee Signature:	Date Completed:			